VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

April 19, 2011

Margaret Perry, Administrator
Cedar Hill Health Care Center
49 Cedar Hill Drive
Windsor, VT 05089

Provider ID #:475046

Dear Ms. Perry:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 30, 2011.**

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 03/30/2011

NAME OF PROVIDER IR SUPPLIER
CEDAR HILL HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
49 CEDAR HILL DRIVE
WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY A FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site complaint survey was Conducted by the Division of Licensing and Protection on 3/30/11. The following regulatory violation was found.	F 000		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Trachaeostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure that nursing staff acted in accordance with policies regarding oxygen humidification for 2 or 3 residents receiving respiratory treatments. (Residents #1 & 2) Findings include: Per observations in resident rooms on 03/30/11 rom 12:20 PM – 12:50 PM, Residents #1 and #2 were receiving oxygen therapy with humidification via oxygen concentrators. There was no date on the pre-filled humidifier bottles for either resident to indicate the date and time the bottle was started. Per review, the facilities policy for oxygen Administration stated under 9.b. "Attach humidifier bottle (if used); date/time the bottle.	F328	Resident # 1 + 2 have tubing and humidifier labeled with the date and time started. Any resident on O2 could be affected by deficient practice. The corrective action is: 1. Policy clarifies the maximum use time of 1 week before disposal of prefilled disposable humidifier bottles. 2. Treatment sheet will have tubing and/or humidifier change for signature by licensed staff to assure consistent practice.	3/30/11

LABORATORY DIRECTOR'S OR PROVIDER/ SUPPLIER REPRESENTATIVES SIGNATURE

Verbal approval by Mary Louise Sayles

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NAME OF PROVIDER IR SUPPLIER CEDAR HILL HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089	

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F 328	Continued from page 1 The policy did not direct staff in the maximum use time before disposal of the prefilled disposable humidifier bottles. The failure to date/time humidifiers was confirmed with the administrator and the owner on 3/30/11 at 3:30 PM.	F 328	This will be the monitoring tool for quality assurance for each resident affected. The DON or designee will assure this practice is being done. They will do a monthly MAR Audit and it will be brought to the Quality Assurance Committee quarterly. F328 POC Accepted 4/19/11 M. Bolton RN / [illegible] RN	